



KANKAKEE COUNTY
HEALTH
DEPARTMENT

2390 West Station Street
Kankakee, Illinois 60901
Phone: 815-802-9400
Fax: 815-802-9391
www.kankakeehealth.org

Please find enclosed a plan review packet. The cost of the plan review will be dependent on what type of risk factor you would be which you can see on page two of the application. The cost of your yearly food license would also be the same.

These plans must be approved prior to the construction or renovation of your facility. As far as the approval time, we try to allow Keith, EH Director, at least one month to review the plans. If the construction is to begin in less than five days, an additional \$200.00 priority fee will be needed.

Once the plans are approved the facility would need to be pre-inspected before opening to the public. The last sheet of the plan review packet should be retained by the facility so that the local code enforcement personnel can also inspect the premises and to sign off on the form previous to our pre-inspection.

If you have any questions regarding the plan review application, please contact Keith Wojnowski at (815) 802-9413.

**KANKAKEE COUNTY HEALTH DEPARTMENT
DIVISION OF ENVIRONMENTAL HEALTH
2390 W. STATION, KANKAKEE, IL 60901
VOICE: (815) 802-9410 FAX: (815) 802-9411**

OFFICE USE ONLY
Amt Rcvd. _____
Cash _____ Check # _____
Card Type _____ App# _____
Date Rcvd. _____ Rcvd By _____
Appvd By _____ Mailed _____

FOOD SERVICE FACILITY PLAN REVIEW

I/we hereby submit plans and specifications to construct, remodel or convert a Food Service Establishment or as a new owner in Kankakee County.

Name of Establishment _____ Home Work Mobile () _____
Street Address _____ City _____ State _____ Zip _____
Licensee/Owner _____ Home Work Mobile () _____
Corporate Owner _____ Home Work Mobile () _____
Mailing Address _____ City _____ State _____ Zip _____
Operator/Manager _____ Home Work Mobile () _____
Email Address _____ Fax Number _____

Are Certified Food Handler(s) on staff? Yes No If so, how many? _____

In an emergency, how can we contact you? Home Work Mobile Email Fax (Please Circle)

Choose one of the following:

- New Construction Change of Ownership (no remodeling)
 Remodel of existing permitted establishment (same owner) Remodel of existing non-permitted establishment
 Remodel of existing permitted establishment (new owner)

A full set of plans, list of equipment to be used in the facility (refrigeration units, freezers, steam tables, etc.), including method of equipment installation and plan review fee ARE TO BE SUBMITTED WITH THIS FORM

ANY CHANGES IN PLANS OR ON THIS FORM MUST RECEIVE ADVANCED APPROVAL

Plans to be returned Yes _____ No _____

The appropriate fee of this plan review is reflected in Section II on Page 2 of this packet.

Signature of owner or authorized agent _____ Date _____

PAYMENT INFORMATION

Please return this completed, signed and dated application and stipulated fee in the form of a check (), cashier's check () or money order () made payable to the **KANKAKEE COUNTY HEALTH DEPT.** Credit card instructions are below.

When you provide a check as payment, you authorize us to use information from your check to process a one-time Electronic Funds Transfer (EFT) or a draft drawn from your account, or to process the payment as a check transaction. When we use information from your check to make an EFT, funds may be withdrawn from your account as soon as the same day we receive your payment and you will not receive your check back from your financial institution. If your payment is returned unpaid, you authorize the collection of your payment plus a return fee of \$25.00 by EFT or drafts drawn from your account.

If you would like to pay by credit card, please fill out the following information:

() Please charge my credit card for the amount as indicated above per the Annual Fee Schedule

Card Type (Please Circle): VISA MASTERCARD DISCOVER AMERICAN EXPRESS
CARD NUMBER: _____ CVS#: _____ EXP. DATE: ____/____/____

SIGNATURE: _____ DATE: _____

II. CLASSIFICATION OF FACILITY

TYPE OF FOOD ESTABLISHMENT

- | | | |
|--|---|--|
| <input type="checkbox"/> Restaurant | <input type="checkbox"/> Gas Station (Retail) | <input type="checkbox"/> Day Care |
| <input type="checkbox"/> Caterer | <input type="checkbox"/> Gas Station (Food Service) | <input type="checkbox"/> Hospital |
| <input type="checkbox"/> Tavern | <input type="checkbox"/> Mobile Unit | <input type="checkbox"/> Long Term Care Facility |
| <input type="checkbox"/> School/Milk Only | <input type="checkbox"/> School/Satellite Kitchen | <input type="checkbox"/> School/Full Kitchen |
| <input type="checkbox"/> Grocery (sq. ft. of building _____) | <input type="checkbox"/> Grocery w/deli (Sq. ft. of building _____) | |
| <input type="checkbox"/> Other _____ | | |

Business Hours _____ to _____ Days Closed _____

Type of Menu _____
 (Copy of menu must be submitted)

- Buffet Set-Up (banquet, salad bars, luncheons, etc.) Yes ___ No ___
- Catering? Yes ___ No ___ Delivery Service? Yes ___ No ___
- Seating Capacity _____
- Public Restroom Provided Yes ___ No ___ Men's ___ Women's ___

To determine the category in which your facility will be classified as, please check all lines that apply to your food preparation activities. This will reflect your plan review fee. If construction has begun or if the establishment is expecting to open in less than a month, an additional \$200.00 priority fee is to be paid in addition to the regular plan review fee.

HIGH RISK FOOD ACTIVITIES (\$500.00)

- Complex preparation including cooking, cooling, and reheating for hot holding involving time/temperature control for safety food;
- Processes requiring hot and cold holding of time/temperature control for safety foods;
- Conducting specialized processes as described in 3-502 of the FDA Food Code; or
- Serving a highly susceptible population as defined in 1-201.10 of the FDA Food Code.

MEDIUM RISK FOOD ACTIVITIES (\$400.00)

- Most products are prepared or cooked and served immediately
- May involve hot and cold holding of time/temperature control for safety foods after preparation or cooking; or
- As approved by the regulatory authority, preparation of time/ temperature control for safety foods requiring cooking, cooling, and reheating for hot holding limited to 2 or fewer same items or processes with approved procedures.

LOW RISK FOOD ACTIVITIES (\$250.00)

- Heating only commercially processed time/temperature control for safety foods for immediate service with no hot holding or assembly
- Only time/temperature control for safety foods commercially prepackaged in an approved processing plant are available or served at the facility
- Only limited preparation of non-time/temperature control for safety foods and beverages, such as snack foods and carbonated beverages, occurs at the facility; or
- Only beverages (alcoholic or non-alcoholic) and garnishes that are non-time/temperature control for safety are served at the facility

CHANGE OF OWNERSHIP NO REMODELING (\$100.00)

III. STORAGE FACILITIES

Kitchen Area in Sq. Ft. _____

Dry Food Storage in Sq. Ft. _____

Type of Shelving: (materials constructed of)

Kitchen _____

Food Storage _____

Walk-in Refrigeration Unit(s) _____

Walk-in Freezer Unit(s) _____

Location of Storage: (in which area of the facility)

Liquor and Beverage _____

Fountain Drink Bulk Bag(s) _____

Cooking utensils _____

Clean Dishware _____

Soiled Dishware _____

Clean/Soiled Linens _____

Location of Chemical Storage:

Soaps & Sanitizers _____

Pesticides/Herbicides/Rodenticides _____

Other Poisonous Material _____

Maintenance Materials (mop, broom, etc.) _____

IV. EMPLOYEES AREA AND HAND WASHING FACILITIES

Projected number of food service employees per shift: _____

Location of storage area for employees' personal belongings: _____

Location of employee washroom: _____

Number of hand washing facilities: _____

Type and materials of hand washing sink: _____

Location of hand washing sinks: _____

Hand washing sink(s) supplied with: Dispensed Towels _____ Dispensed Soap _____

(Any self-closing of metering faucet shall be designed to provide a flow of water for at least 15 seconds without the need to reactivate the faucet)

V. PLUMBING

Water Supply Type Public [] Private []

Sewage Disposal Type Public [] Private []

Food Preparation Sink Yes _____ No _____ Location _____
 Sink Dimensions Length _____ Width _____
 Materials _____ Depth _____ Gallons _____
 Number of compartments _____

Janitorial Sink Type _____ Location _____ Materials _____
 (Provide back-siphon prevention devices on all threaded faucet that a hose is intended to be attached to)

Grease Interceptor Yes _____ No _____ Location _____
 Indoor Recessed [] Outdoor Recessed []

Size of Grease Interceptor _____ gallons (volume of sink(s) x .50 = volume of grease interceptor)

Garbage Grinder Yes _____ No _____ Location _____

- Garbage grinder, if installed, must be directly connected with a floor drain relief.
- Gutters or other methods of protecting food in preparation and storage areas from overhead sewer lines are to be provided.
- Must meet all applicable requirements of local or state plumbing code.

<u>Potable Water Protection Provided</u>		<u>Indirect Waste Connection Provided</u>	
N/A	Type	N/A	Yes
[] _____	Toilets	[]	[] Refrigerator Drains
[] _____	Urinals	[]	[] Refrigerator Condensate
[] _____	Dish Machines	[]	[] Steam Table(s)
[] _____	Garbage Grinders	[]	[] Ice Maker/Bin(s)
[] _____	Threaded Water Outlets	[]	[] Utensil & Glass Washing Sink
[] _____	Carbonators	[]	[] Food Preparation Sink(s)
[] _____	Janitorial Sprays	[]	[] Dipper Well(s)
[] _____	Soap/Chem. Dispenser	[]	[] Dish Machine(s)
[] _____	Coffee Machine	[]	[] Garbage Grinder(s)
[] _____	Other Water with Potable	[]	[] Soda Dispenser(s)
	Water Connections	[]	[] Salad Bar/Buffer
		[]	[] Other _____

VI. SANITIZING EQUIPMENT AND FACILITIES

Water heater Capacity _____ Gallons

Manual Dish Washing

Three Compartment Sink _____ Chemical [] or Hot Water Sanitizing []

Volume of Sink Size of Compartment $\left(\frac{\text{Length} * \text{Width} * \text{Depth} * 3}{231} \right) = \text{_____ gallons}$

$\left(\frac{\text{Length} * \text{Width} * \text{Depth} * 3}{231} \right) = \text{gallons}$

Length of Each Drain-board _____ inches Total Length of Sink _____ inches

MECHANICAL DISH AND/OR GLASS WASHING

Dish machine Manufacturing and Model Number _____ -

Length of Soiled Dish Table _____ ft. Soiled Dish Table Draining into _____
Length of Clean Dish Table _____ ft.

[] Chemical Sanitizing Machine _____
Dish machine Demand of Rinse Water _____ GPH
Warning Indicator on Chemical Dispenser Provided

[] Hot Water Sanitizing Machine _____
Dish machine Demand of Rinse Water _____ GPH @ 20 PSI Flow Pressure

Booster Heater Manufacturer and Model Number _____

Located _____ Ft. From Dishwasher Supply Pipe Insulated Yes [] No []
Temperature Gauge Installed After Booster Heater _____
Pressure Regulator Installed on Final Rinse Line _____

All other types of sanitizing methods (steam or low pressure) must be described in writing and be supported with the equipment manufacturer's specification.

VII. GARBAGE AND REFUSE DISPOSAL

Type of Disposal: [] Dumpster [] Compactor [] Incinerator [] Grease Barrel
Other: _____
Covers Provided: Yes _____ No _____
Grease Disposal Company _____

Garbage Area: [] Asphalt [] Concrete
Draining to: _____
Enclosed: Yes _____ No _____ Type of Enclosure: _____

VIII. LIGHTING

N/A	Yes	
[]	[]	Adequate light provided in kitchen/utensil washing area (min 50 ft. candles)
[]	[]	Adequate light provided at bar/fountain glass washing sink (min 20 ft. candles)
[]	[]	Adequate light provided in food/utensil storage rooms, toilets and dressing room (min 30 ft. candles)
[]	[]	Protective shielding provided for lighting fixtures over all preparation, display, food storage and utensil washing areas

IX. MISCELLANEOUS

- | N/A | Yes | |
|--------------------------|--------------------------|---|
| <input type="checkbox"/> | <input type="checkbox"/> | All washrooms shall have self-closing doors |
| <input type="checkbox"/> | <input type="checkbox"/> | Soap and paper towels provided at each hand sink |
| <input type="checkbox"/> | <input type="checkbox"/> | Provide test strips for the sanitizer intended to be used |
| <input type="checkbox"/> | <input type="checkbox"/> | Provide metal stem thermometer for monitoring hot food temperatures |
| <input type="checkbox"/> | <input type="checkbox"/> | All washrooms shall have mechanical ventilation |
| <input type="checkbox"/> | <input type="checkbox"/> | All exterior doors shall have self-closing devices and be tight fitting |
| <input type="checkbox"/> | <input type="checkbox"/> | Ventilation units shall be screened with 1/16" mesh |
| <input type="checkbox"/> | <input type="checkbox"/> | Thermometers shall be located in all refrigeration/freezer units |
| <input type="checkbox"/> | <input type="checkbox"/> | Proper dispensers for single service articles shall be used |
| <input type="checkbox"/> | <input type="checkbox"/> | Sneeze guards shall be provided to properly protect displayed foods |
| <input type="checkbox"/> | <input type="checkbox"/> | All exposed plumbing, electrical, gas, & refrigeration lines shall be 6" off of the floor and 1/2" away from wall |
| <input type="checkbox"/> | <input type="checkbox"/> | All open-able windows shall be screened with 1/16" mesh screen |
| <input type="checkbox"/> | <input type="checkbox"/> | Carry-out windows shall be protected |
| <input type="checkbox"/> | <input type="checkbox"/> | Laundry operations separate from food service areas |
| <input type="checkbox"/> | <input type="checkbox"/> | Cold plates integral with ice bins |
| <input type="checkbox"/> | <input type="checkbox"/> | Certified Food Protection Manager shall be present based on establishment classification |

Status: Plans unapproved Date _____
 Plans approved Date _____
 More information requested: _____

CONSTRUCTION SHALL NOT BEGIN UNTIL AFTER PLANS HAVE BEEN SUBMITTED AND APPROVED.

Health Department Representative: _____
Date: _____

A 48 hour notice must be given to the Kankakee County Health Department for a final inspection prior to opening. A preliminary inspection must be conducted after all equipment has been installed.

NO FOOD SHALL BE STOCKED IN THE FACILITY UNTIL APPROVAL HAS BEEN GRANTED BY THE HEALTH DEPARTMENT REPRESENTATIVE

Full equipment list, method of installation, and architectural plans are to be submitted with this form to the

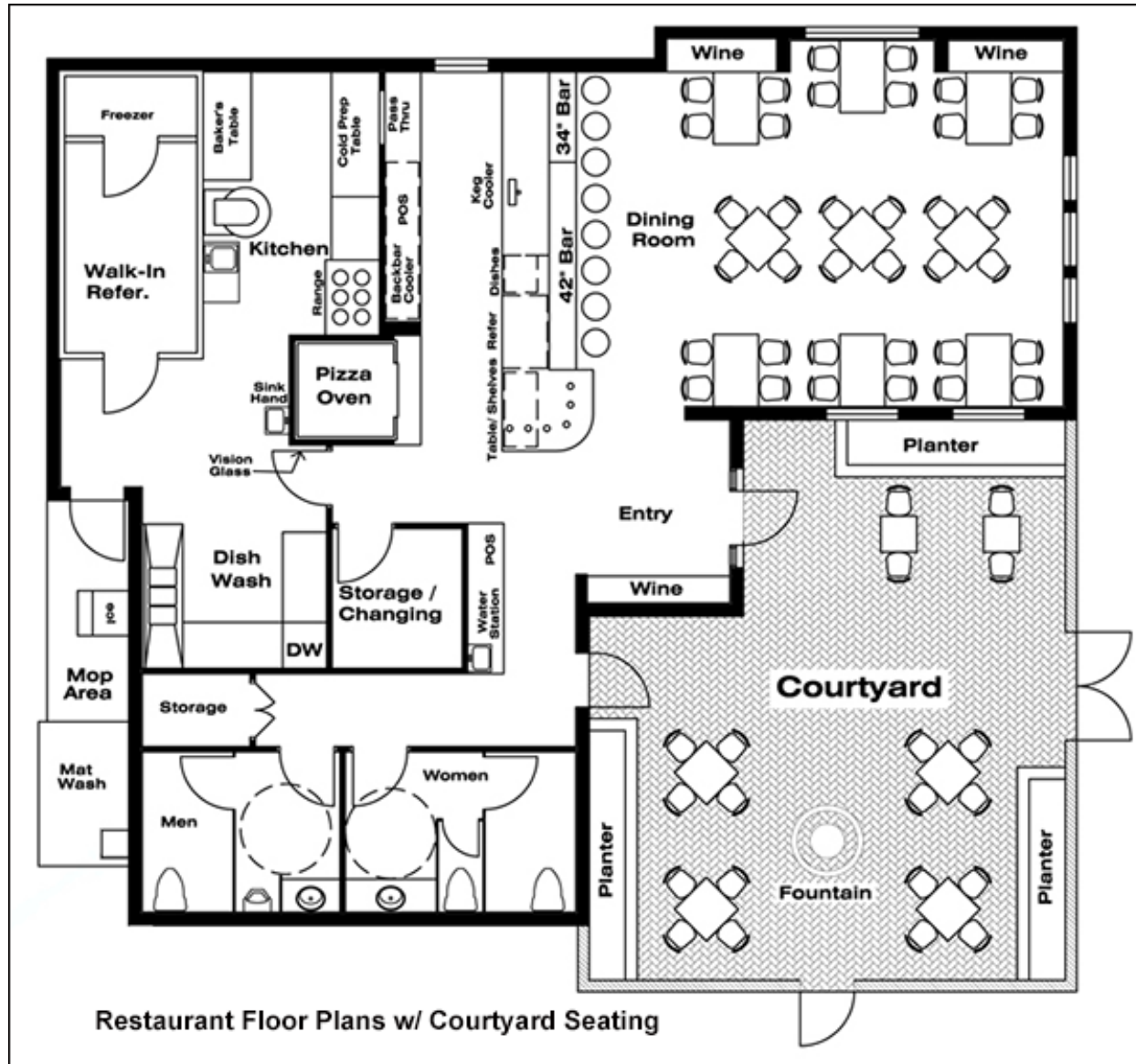
Kankakee County Health Department
Environmental Health Division
2390 W. Station St.
Kankakee, IL 60901

III. Room Finish Schedule

Room Area	Floor	Floor Base or Cove	Walls	Ceiling	Comments
Food Preparation					
Cookline					
Utensil Washing					
Food Storage					
Walk-in Refrigerator/ Freezer					
Janitorial Areas					
Waitress Areas					
Bar					
Restrooms					
Dressing & Locker Room					
Buffet & Salad Bars					
Other					

**Specific brand names and colors for materials should be specified whenever possible to ensure acceptability

Provide drawing of facility including location of plumbing, equipment, etc.
EXAMPLE



KANKAKEE COUNTY HEALTH DEPARTMENT

REFERRAL FORM FOR FOOD ESTABLISHMENTS

1. Date _____
2. Establishment Name _____
3. Establishment Address _____
4. Establishment Phone _____
5. Applicant's Name _____
6. Applicant's Address _____
7. Applicant's Phone _____

Type of Development

- New Facility
- Remodel of licensed facility
- Remodel of unlicensed facility
- Change of Ownership – No remodel

The below listed agencies must be contacted and perform their inspections of the above facility prior to the Kankakee County Health Department's Environmental Health inspector performing their inspection.

All inspections from each agency must print their initials and date this referral form:

- City Code Enforcement
- Building Department
- Plumbing Inspector
- Fire Inspector
- Health Inspector

Building Department
Conditional Approval Granted:
Reviewer: _____
Date: _____

Plumbing Inspector
Conditional Approval Granted:
Reviewer: _____
Date: _____

City Code Enforcement
Conditional Approval Granted:
Reviewer: _____
Date: _____

Electrical Inspector
Conditional Approval Granted:
Reviewer: _____
Date: _____

Fire Inspector
Conditional Approval Granted:
Reviewer: _____
Date: _____

Health Dept. Inspector
Conditional Approval Granted:
Reviewer: _____
Date: _____